More jobs, better pay, *more nurse imposters*

The number of people caught posing as nurses in the District and across the nation, is increasing and will probably continue to rise as a result of a national nursing shortage.

The potential for harm is significant, say nursing managers, as nurses provide critical care at every level of the health care system.

Though it is illegal to pose and practice as a nurse without a license, experts say more people are trying because of the high demand, good pay and incentives used to attract nurses. With that kind of market, "You're going to see people who are going to look

for opportunities," said Dawn Kappel, director of marketing and communications for the National Council of State Boards of Nursing.

The typical imposter nurse has some nursing education or experience, but the license may have been revoked or only valid in another state. Or they may either overstate their credentials or have none at all.

Not all imposters make it to the practice setting—employers often catch them during the hiring process. The board therefore urges employers to check job applicants' original documents. And to check our website at *http://hpla.doh.dc.gov/weblookup/* to assure that they are licensed in good standing in the District.

FAKING QUALIFICATIONS

In most cases, imposter nurses are faking documents or credentials to land jobs.

In the District we had an applicant for licensure by examination that submitted fraudulent documents --- a letter of endorsement "signed" by the school's administrator, a transcript and certificate of graduation with a school seal. Fortunately we were able to identify him as an imposter prior to his becoming licensed and working in DC.

In another case an alert human resources person noticed that the nurse's District RN license expired in an odd-numbered year (licenses for RNs in the District expire in even-numbered months, LPNs odd-numbered months).

Last month two imposters were identified. One was discovered during a raid in which many licenses of various kinds were recovered. In another case, the facility was unable to validate the "nurses" licensure status and she could not produce verification of her status. She was reported to the Board and our investigators found that she was not licensed---she had placed her name on someone else's license.

Like most boards the District Board of Nursing does not have jurisdiction over imposters. The Board only has jurisdiction over licensed nurses or applicants for licensure. So they cannot discipline the imposters or press charges.

In a neighboring state, a man misrepresented himself as a licensed practical nurse. The man, while certified as a nursing assistant, did not have a nursing degree but practiced as an LPN at a health care facility. Although he had completed a practical nurse program he had not yet passed his licensure examination. While his case was being reviewed by another Board of Nursing he applied to sit for examination in the District. After verifying his licensure status and determining that he was a nurse imposter, the DC Board referred his request for licensure to the Office of the Attorney General.

According to Van Brathwaite, the Board of Nursing's Attorney Advisor, when Health Professional Licensing Administration becomes aware of a person posing as a licensed nurse we will request the Attorney General's Office to prepare a cease and decease order requiring the person to cease and desist immediately from practicing as a nurse. If the person does not comply he/she is referred for prosecution.

TEMPTING MARKET

The strong market for qualified nurses is a tempting target for people who pose as nurses.

According to the U.S. Bureau of Labor Statistics, more than 1 million nurses will be needed by 2012.

It's more lucrative nowadays for people to pretend to be nurses. People know that facilities are desperate to hire nurses. According to a District Nursing Administrator, an entry-level registered nurse can expect to start out earning $22 per hour—about $45,600 a year—not including signing bonuses and overtime pay that can boost their base pay.

More imposters are using fake documents when applying for jobs. Some use another nurse's license as their own or change the expiration date on their own license.

They also overstate their credentials, saying they are a registered nurse when they are in fact a licensed practical nurse. An RN has completed more education and can perform more clinical procedures compared to an LPN.

Employers are encouraged to check the original document; imposters have

often altered copies of documents. And in the District while we have placed pictures on licenses to help employers to identify imposters we encourage health care facilities to check our website at *http://hpla.doh.dc.gov/weblookup/*

TRACKING IMPOSTERS

When an imposter nurse is discovered in the District, we encourage employers to contact the Board of Nursing. Board investigators will check their records to see if the person's license number belongs to the individual. When they find out that the person is impersonating a nurse, the board sends a cease and desist letter to tell that person to stop practicing. They then refer most cases to the Office of the Attorney General.

Kappel said it's difficult to track the number of imposters on a national level or to compare the numbers in other states because some imposter nurses fall in between the cracks.

For many states, it's not the nursing boards' job to find imposter nurses, she said. Also, imposter nurses who are already working in a hospital may not get caught until something triggers suspicion. ■

Source: *Portions of this article were adapted from "Plentiful jobs, high pay mean more nurse imposters" which appeared in The Arizona Republic on July 27, 2005, written by Sherry Anne Rubiano, about nurse imposters in Arizona.*

Alert: DC Nurse Imposters

It has come to the attention of the District of Columbia Board of Nursing that the licensure status of JANICE LASTER OJEHONMON (LICENSE # RN68204) cannot be validated. A person may be practicing in the District in possession of a RN license with the above name. If you are aware of a person working in the District of Columbia licensed as JANICE LASTER OJEHONMON, RN please notify the Board ASAP.

It has come to the attention of the District of Columbia Board of Nursing that the licensure status of RAMATU DAINKEH, LPN, cannot be validated. A person may be practicing in the District in possession of a LPN license with the above name. If you are aware of a person working in the District of Columbia licensed as RAMATU DAINKEH, LPN, please notify the Board ASAP. ■

IF YOU SUSPECT OR KNOW OF AN INDIVIDUAL ATTEMPTING TO PRACTICE NURSING WITHOUT A LICENSE, CONTACT THE DC BOARD OF NURSING:

District of Columbia Board of Nursing
717 - 14th Street, NW, Suite 600
Washington, DC 20005
Fax: (202) 727-8471

Board Disciplinary Actions

NAME	LICENSE #	ACTION	REASON FOR ACTION
Veronique Taylor, LPN	LPN5371	Failure to conform to standards of acceptable conduct and prevailing practice. Demonstrated a willful or careless disregard for the health, welfare, or safety of a patient.	Suspended for a period of six (6) months. All of the suspension stayed with the exception of one (1) day to commence upon receipt of the Final Decision and Order of the Board.

Board of Nursing Survey

The Board of Nursing will be seeking your assistance in our effort to improve Board services. The National Council of State Boards of Nursing will be sending surveys to a select group of District of Columbia **Nurses, Employers, Nurses Complained Against,** and **Educational Programs**.

Your decision to participate is voluntary and your responses will be kept confidential. Board members and staff will not have access to any individual responses. The identification number printed on the questionnaire will be used only to record that it has been returned. Responses will be tabulated at the National Council of State Boards of Nursing and provided to the Board and staff in aggregate counts and percentages. Individual survey responses will be destroyed after tabulations are completed.

Your participation in this study is critical. We hope you take advantage of this unique opportunity and contribute to the Board's understanding of the impact of its work. Your participation will greatly help us improve our services. ■

Continued Competence in Nursing

The National Council of State Boards of Nursing (NCSBN) recently initiated practice analysis studies: one for post entry-level registered nurses (RNs) and one for post entry-level licensed practical and vocational nurses (LPN/VNs). Designed to describe post entry-level nursing practice and delineate the interface between entry-level practice and continued competence in practice, NCSBN convened panels of experts, two for RNs and another for LPN/VNs, to develop nursing activity statements that will be used in the practice analysis questionnaires.

Throughout its 27-year history NCSBN has advanced the position that nurses must remain competent throughout their professional careers. To assist boards of nursing in addressing continued competence, NCSBN is spearheading an initiative to develop an assessment instrument to measure continued competence of RNs and LPN/VNs. This past summer NCSBN convened the panels of RN and LPN/VN subject matter experts who were drawn from a wide spectrum of nursing organizations representing major practice and specialty settings, education programs as well as geographic locations and major employing facilities. The panel members used their expertise to create a list of nursing activity statements that could be used to describe post entry-level practice.

Each of the panels worked to refine a list of nursing activities until they had developed a comprehensive list of nursing competencies that reflected post-entry level practice throughout the country.

The nursing professionals who will respond to the surveys will be asked to determine the importance of each of the activities listed in the post entry-level nursing activity statements. Data collection for the LPN/VN survey began in October 2005 with the collection process for RNs anticipated to begin in January 2006. All nurses receiving the survey are strongly encouraged to complete and return it as their participation in this study offers a unique opportunity to contribute to the nursing profession.

For more information about NCSBN's work on continued competence for nurses, access the NCSBN Web site at *www.ncsbn.org*. ■

Medical Errors Database

President Bush signed into law Senate Bill 544 that will create a national database on medical errors, designate individual reports as confidential and shield participating providers from liability. Patient-safety organizations (PSOs) will collect voluntary reports from providers, analyze the data and recommend steps to avoid future mistakes. The patient safety organizations would contract with the providers to identify trends and develop proposals to prevent future medical errors. The data would not identify specific patients, providers or individuals who report medical errors. In addition, patients could not use the data as evidence in medical malpractice lawsuits or other litigation, and accrediting bodies or regulators could not use the data to take action against providers.

Many providers believe that the Patient Safety and Quality Improvement Act will eliminate barriers to reporting errors and ultimately will lead to better patient care. Lawmakers have discussed this legislation over the last three sessions of Congress, and NCSBN has provided comments and monitored this initiative closely. The National Academy for State Health Policy reports that 23 states currently have medical error reporting systems, with all but one mandatory. Some states, such as Minnesota, publish data on medical errors reported by hospitals, and others, such as Florida, track errors but do not release hospital names. According to supporters of a voluntary national medical error reporting system, confidentiality will encourage providers to report errors. However, some consumer advocates and patient safety experts maintain that such a system could duplicate efforts by state groups.

Although the law will not permit reports to PSOs to be shared with the regulatory boards or under the Freedom of Information Act, we do not believe this will jeopardize access the information you are currently getting. Exceptions include information of evidence of a criminal act, or if the provider authorizes it, etc. Under rules of construction, nothing shall be construed as "preempting or otherwise affecting any state law requiring a provider to report information that is not patient safety work product." Within the network of PSO databases, information will be shared and exceptions to the confidentiality provisions are waived for research purposes and non-identifiable provider information. The law mandates a report to Congress within a year of operationalizing this effort. Criteria for who can apply to be a PSO is also included in the law. (See the law at http://thomas.loc.gov/cgi-bin/query/C?c109:./temp/~c109BC7qwb) ■

Correcting Error-Prone Aspects of Prescription Writing

The National Coordinating Council for Medication Error Reporting and Prevention emphasizes that illegibility of prescriptions and medication orders has resulted in injuries to, or deaths of patients. The Council, therefore, has made the following recommendations to help minimize errors.

- **All prescription documents must be legible. Prescribers should move to a direct, computerized, order entry system.**
- **Prescription orders should include a brief notation of purpose (e.g., for cough), unless considered inappropriate by the prescriber.** Notation of purpose can help further assure that the proper medication is dispensed and creates an extra safety check in the process of prescribing and dispensing a medication. The Council does recognize, however, that certain medications and disease states may warrant maintaining confidentiality.
- **All prescription orders should be written in the metric system except for therapies that use standard units such as insulin, vitamins, etc. Units should be spelled out rather than writing "U."** The change to the use of the metric system from the archaic apothecary and avoirdupois systems will help avoid misinterpretations of these abbreviations and symbols, and miscalculations when converting to metric, which is used in product labeling and package inserts.
- **Prescribers should include age, and when appropriate, weight of the patient on the prescription or medication order.** The most common errors in dosage result in pediatric and geriatric populations in which low body weight is common. The age (and weight) of a patient can help dispensing health care professionals in their double check of the appropriate drug and dose.
- **The medication order should include drug name, exact metric weight or concentration, and dosage form.** Strength should be expressed in metric amounts and concentration should be specified. Each order for a medication should be complete. The pharmacist should check with the prescriber if any information is missing or questionable.
- **A leading zero should always precede a decimal expression of less than one. A terminal or trailing zero should never be used after a decimal.** Ten-fold errors in drug strength and dosage have occurred with decimals due to the use of a trailing zero or the absence of a leading zero.
- **Prescribers should avoid use of abbreviations including those for drug names (e.g., MOM, HCTZ) and Latin directions for use.** The abbreviations in the chart below are found to be particularly dangerous because they have been consistently misunderstood and therefore, should never be used. The Council reviewed the uses for many abbreviations and determined that any attempt at standardization of abbreviations would not adequately address the problems of illegibility and misuse.
- **Prescribers should not use vague instructions such as "Take as directed" or "Take/Use as needed" as the sole direction for use.** Specific directions to the patient are useful to help reinforce proper medication use, particularly if therapy is to be interrupted for a time. Clear directions are a necessity for the dispenser to: (1) check the proper dose for the patient; and, (2) enable effective patient counseling.

In summary, the Council recommends: ***Don't Wait . . . Automate! When In Doubt, Write It Out! When In Doubt, Check It Out! Lead, Don't Trail!***

DANGEROUS ABBREVIATIONS

Abbreviation	Intended meaning	Common Error
U	Units	Mistaken as a zero or a four (4) resulting in overdose. Also mistaken for "cc" (cubic centimeters) when poorly written
µg	Micrograms	Mistaken for "mg" (milligrams) resulting in an overdose.
Q.D.	Latin abbreviation for every day	The period after the "Q" has sometimes been mistaken for an " I, " and the drug has been given "QID" (four times daily) rather than daily.
Q.O.D.	Latin abbreviation for every other day	Misinterpreted as "QD" (daily) or "QID" (four times daily). If the "O" is poorly written, it looks like a period or " I ."
SC or SQ	Subcutaneous	Mistaken as "SL" (sublingual) when poorly written.
T I W	Three times a week	Misinterpreted as "three times a day" or "twice a week."
D/C	Discharge; also discontinue	Patient's medications have been prematurely discontinued when D/C, (intended to mean "discharge") was misinterpreted as "discontinue," because it was followed by a list of drugs
HS	Half strength	Misinterpreted as the Latin abbreviation "HS" (hour of sleep).
cc	Cubic centimeters	Mistaken as "U" (units) when poorly written.
AU, AS, AD	Latin abbreviation for both ears; left ear; right ear	Misinterpreted as the Latin abbreviation "OU" (both eyes); "OS" (left eye); "OD" (right eye)

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